STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152028	A. BUILDING 00 B. WING	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF NORTHWESTERN INDIANA	9509 GEORGIA ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for one (1) State hospital complaint investigation. Complaint: #IN 00100939 Substantiated; deficiency related to allegations is cited. Facility: # 012131 Date: 1-25-2012 Surveyor: Deborah Franco, RN Public Health Nurse Surveyor QA: claughlin 04/03/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.			
	Based on document review and interview, the governing board failed to ensure that all services have written policies and procedures in relation to collection of blood specimens for two (2) services (nursing and laboratory). Findings included: 1. Review of orientation and training material document used as part of the annual training material for RN's and LPN's states on page 1, "Blood Specimen Collection" [step] 1. Review policy and procedure". 2. During interview with S3 on 1-25-2012 at 2:15 PM, S3 stated that: a. S3 is the interim CCO of the facility responsible for patient care. b. orientation and annual training of RN's	S0322	Per the above Plan of Correction Guidelines: 1. No specific patients were mentioned in deficiency number S 03222. New policy developed entitled, "Blood Specimen Collection". Policy review inservices have been conducted for licensed nursing staff and contracted phlebotomists regarding Blood Specimen Collection based on the blood collection procedures contained within the policy. Responsible Party: Chief Clinical Officer with assistance from the Director of Quality. 3. Policies and procedures were reviewed. The Blood Specimen Collection Policy was created to ensure proper written procedures were available to staff. Policy review inservices were conducted for all licensed nursing staff. The policy was presented for approval at the Quality Committee followed by	02/25/2012

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	and LPN's includes competency for collection of blood specimens. c. when contracted laboratory phlebotomists are not on duty (before 5:00 AM or after 7:30 AM) the RN's and LPN's obtain blood specimens for ordered laboratory tests. d. training material used annually to determine competency of nurses to draw blood specimens requires that the nurse first refer to the facility policy for blood specimen collection. e. the facililty does not have written policies and procedures for the use of nursing services or laboratory services in relation to the collection of blood specimens to which employees or contracted service providers can refer in order to comply with facility standards.		Meddical Executive Committee approval and GB approval. Responsible Party: CEO with assistance from Director of Laboratory. 4. The Chief Executive Officer is responsible for ensuring policies are in place for services the hospital provides. The Chief Clinical Officer will review clinical policies and procedures in a systematic manner to ensure this is met and report and correct any deficiencies to the CEO and the monthly Quality Committee, MEC and Governing Board. Responsible Party: Chief Executive Officer with assistance from the Director of Quality.	